Statement
of
American College of Surgeons

to
House Energy and Commerce Committee
Subcommittee on Health

by
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on
Medicare Physician Payments: 2007 and Beyond

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Chairman Deal, Ranking Member Brown, and distinguished subcommittee members, thank you for the opportunity to testify today on behalf of the 71,000 Fellows of the American College of Surgeons (ACS). My name is Tom Russell and I am the College's Executive Director.

We are grateful to you for holding this hearing on Medicare physician payments, and on the legislation that is needed to build a system to provide high-quality care for Medicare beneficiaries in the future. We are grateful to Chairman Barton, Dr. Burgess, and Ranking Member Dingell for drafting legislation that would stop the 5.1 percent cut in physician reimbursement that is scheduled to take effect on January 1, and we owe special thanks to Melissa Bartlett who works on Chairman Barton's staff.

All three proposals offer a multi-year approach for addressing this issue, and all three would replace the scheduled reduction in the fee schedule conversion factor with at least modest increases in payments. Given all the other payment policy changes that will be taking effect in 2007, this certainly is the approach we recommend. However, if agreement on a more comprehensive or long-term strategy continues to elude us as the 109th Congress draws to a close, it is vitally important that Congress takes, *at a minimum,* the steps that are necessary to prevent the 5.1 percent cut on January 1.

While value-based purchasing can improve the overall quality of care that patients receive and allow them to make more informed decisions about their care, more is needed to fix the broken Medicare payment system. The benefits of a value-based purchasing system will not be fully realized until a fair and stable physician payment system is implemented. The College urges Congress to prevent the 5.1 percent payment cut that will go into effect on January 1, and to actively explore long-term solutions to this ever-growing problem.

Unique issues facing surgery

The coming year will be especially difficult for surgical practices, due to a confluence of three factors:

- ***Five-year review.*** Every five years, CMS is required by law to comprehensively review all work relative value units (RVUs) in the Medicare physician fee schedule and make any needed adjustments in a budget-neutral manner. This coming year, there will be a significant shift in payments that will increase reimbursement for visit services by over $4 billion--an amount that exceeds total Medicare spending for services provided by the specialties of general surgery, neurosurgery, cardiac surgery, and colorectal surgery *combined*. As a result, *payments for all but a very few surgical services will be reduced significantly even if Congress passes legislation to increase the fee schedule conversion factor.*

- ***Practice expense payments.*** Changes are also being implemented in practice expense RVUs, both as a result of incorporating new practice cost data for some specialties and because of "downstream" effects of the increase in work RVUs. Practice expense RVUs are determined by a formula that takes into account the amount of work involved in providing each service. As work RVUs increase or decrease following the five-year review, subsequent changes are produced in the practice expense values. Because work values for surgical services overall are falling, the practice expense values for surgery will be reduced, as well.

- ***ASC payment changes.*** Facility payments are undergoing changes as a result of the Deficit Reduction Act provisions that cap payments to ambulatory surgical centers (ASCs) at the amounts paid under the hospital outpatient prospective payment system. Other regulatory changes planned in 2008 will further impact these payments. For some specialties, a significant portion of their services are provided in ASCs, and many of these facilities are physician-owned. For a specialty like ophthalmology, which is experiencing payment reductions as a result of the five-year review and practice expense changes, the compound effect will be very significant.

Finally, it is important to realize that the conversion factor reductions produced by the sustainable growth rate system (SGR) were not due to increased service volume in major procedures. Surgical service volume growth, on average, has remained well within the SGR target rates. In effect, surgeons have been paying the price for volume increases occurring elsewhere in the healthcare system. It is for this reason that the College has endorsed the concept of establishing a system of separate expenditure targets and conversion factors for various categories of physician services.

Access issues are beginning to emerge

The effects of Medicare payment trends are being felt throughout the health care system, and surgical care access issues are becoming more evident. In May, the

Institute of Medicine issued a series of reports on the *Future of Emergency Care,* which noted that many of the nation's emergency departments and trauma centers are experiencing shortages in the availability of on-call specialists. Surgeons provide lifesaving care to patients suffering from both traumatic injuries and medical emergencies. Patients suffering from strokes, blockages, and injuries often require timely treatment in order to prevent permanent disability or even death. Without the prompt availability of on-call surgeons, these patients do not receive the services they desperately need.

In an ensuing report entitled *A Growing Crisis in Patient Access to Emergency Surgical Care*, the College documented this problem further. The supply of surgeons has not kept pace with the patient population, a significant number are reaching retirement age, and more are taking advantage of hospital bylaws provisions that allow older surgeons to opt out of emergency call service.

But, the cause for concern is not limited to the emergency setting. A recent report from the Association of American Medical Colleges confirms that the population of surgeons in practice is getting old. The nation's training system has been producing the same number of surgeons for decades, despite a growing and aging patient population. As a result, data on the proportion of active physicians over age 55 show that every surgical specialty is above the national average of 33.3 percent. In four specialties that provide significant amounts of care to elderly patients—general surgery, orthopaedic surgery, urology, and thoracic surgery—the number is well over 40 percent.

We are growing very concerned that additional stress on the financial viability of surgical practices will take us to the breaking point, and many of those surgeons who are near retirement age will opt to leave practice altogether. Given the length of time it takes to train a surgeon (averaging six to nine years following medical school, depending on the specialty), any access problems that may result because of early retirements will be difficult to remedy.

Legislative proposals

Rather than individually addressing each of the legislative proposals pending before the committee, I would like to offer comments on various aspects they encompass, most of which are common to all of them.

Update for 2007. Surgeons cannot continue to shoulder steep cuts in reimbursement for major procedures. This trend first emerged in the late 1980s, and Medicare payments for many procedures already are half what they were nearly two decades ago, without taking into account the effects of inflation. It is important that any final legislative proposal includes an increase in Medicare reimbursements to all physicians in 2007, and in any subsequent years. And, because past efforts to avoid conversion factor cuts had the effect of simply postponing the inevitable by pushing the sustainable growth rate (SGR) debt to future years, we believe strongly that any long- or

short-term solution must be treated as a change in law and regulations and so not contribute to increased spending under the SGR.

Quality Reporting. While the College agrees that value-based purchasing can improve the quality of care patients receive, there have been numerous obstacles to surgical participation in Medicare's Physician's Voluntary Reporting Program (PVRP). Consequently, we support the concept of a "ramp up" year as envisioned in Chairman Barton's draft legislation.

Many had hoped that by the end of 2006, enough evidence-based quality measures would have been developed to allow all physicians to participate in a Medicare quality reporting program beginning January 1, 2007. In fact, the combined effort of all the specialties has been remarkable and significant progress has been made. Notably, the multi-specialty process provided by the Physician's Consortium for Performance Improvement has gained broad acceptance across the profession, and will soon produce enough well-vetted measures to cover the majority of specialties, if not yet the majority of physicians. It is important that any value-based purchasing program embrace this process of measure development.

Because of the challenge in developing evidence-based measures that cover all physicians, the College strongly supports Chairman Barton's proposal to allow physicians the option of participating in the PVRP or reporting on three structural measures. We also recommend that legislation include a "hold harmless" provision so that no physician is unfairly penalized if there are no PVRP or structural measures that apply to them.

With respect to the medical home demonstration project in Chairman Barton's draft, we have two concerns. First, we believe the care coordination language should not be limited to chronic conditions. Other conditions and services—notably cancer care—frequently involve the expertise of multiple specialists and extend over long periods of time, although they are not considered "chronic." We would like to see this language expanded to provide authority to CMS to create demonstration projects related to long-term disease management beyond primary care services.

Second, the draft legislation also counts physicians who are participating in the medical home demonstration project as fulfilling the quality reporting requirement. Since the demonstration project involves additional payments for services not currently reimbursed under Medicare, we question whether it is appropriate to also provide bonus payments for the very same activities. We recommend that the demonstration project be considered a separate component of the legislation and not be treated an option for quality reporting.

Utilization review. Two of the legislative proposals would also provide a greater role for the Quality Improvement Organizations (QIOs) and expand their purview to include utilization review. We agree that an educational program that informs surgeons about regional variations in care and that compares their utilization and

service volume to others should prove very beneficial. However, it is important to keep in mind that many physicians sub-specialize, and for them physician-specific volume comparisons may be of little value. Practice trends and utilization will also vary by practice settings—a trauma surgeon in a Level I trauma center, for example, will likely provide more critical care services than other general surgeons in the community. Nonetheless, making the data available will no doubt be constructive and provide the basis for close examination at local clinical education sessions.

In addition, the confidentiality, feedback loop, and the non-punitive nature of the program are all very important for physicians to actively participate and we are grateful that these requirements have been included in the legislation.

We have some concern, however, about whether state medical societies typically have the resources needed to coordinate utilization review programs. We would suggest that some consideration be given to allowing national organizations to manage such efforts if they are able to provide state-specific feedback.

Removing limits on balance billing. Surgeons have always had the highest rates of participation in the Medicare program. Nonetheless, after decades of cost controls and payment cuts, I suspect many of our members would welcome removal of the statutory limits on balance billing for high-income beneficiaries. We do, however, have some practical concerns with the language included in Dr. Burgess' bill (and that we expect will be included in Chairman Barton's bill).

Determining a patient's annual income really is not feasible for the typical physician practice. Physicians do not have ready access to this information, and raising income issues directly with patients at the point of care is not conducive to the trusting relationship that is so important between a surgeon and his or her patient.

In addition, under current rules Medicare sends reimbursement for unassigned claims directly to the beneficiary rather than to the physician. This presents a particularly difficult situation for surgeons providing major procedures in the hospital setting. Surgical patients do not bring their wallets to the operating room. So, unlike office-based services, it simply is not feasible to ask for payment at the time of service. Instead, a surgeon's bill that is received after discharge must compete for payment with many other—often significantly larger—invoices that the patient receives from other physicians, the hospital, labs, and so forth. The end result is a significant lag in payment and, in the worst situations, no payment at all.

Significant changes would need to be made in the current rules governing balance billing before removing the 115 percent limit could have any meaningful impact on surgical services.

Conclusion

While the College greatly appreciates Congress' actions over the past four years to prevent the payment cuts, it is more important than ever that action be taken to prevent the 5.1 percent conversion factor reduction that is scheduled to take effect on January 1, 2007. Not only have payments failed to keep pace with the rising cost of caring for Medicare patients in recent years, but other payment policy changes will compound the impact on an aging surgical workforce in 2007. Even with action to prevent the conversion factor reduction in 2007, some surgical services are likely to experience double-digit percentage reductions in Medicare payments, which is one of the reasons that surgery supports a multi-year approach to addressing the problem.

Mr. Chairman, thank you for providing this opportunity to share with you the challenges facing surgeons under the Medicare program today, and to provide specific feedback on the various legislative proposals. Whether the focus is on value-based purchasing or on the sustainable growth rate, the College looks forward to continuing to work with you to reform the Medicare physician payment system to ensure that Medicare patients will have access to the high-quality surgical care they need.